STATEMENT

PhRMA
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In Support of Connecticut Senate Bill 24

February 4, 2015

Position: PhRMA supports Connecticut SB 24, which prohibits health insurers from 1(A) implementing drug formularies that place a prescription drug in a nonpreferred cost-sharing tier unless at least one prescription drug that is in the same therapeutic class and is a medically appropriate alternative treatment for a given disease or condition is available on the preferred tier, or (B) making certain changes to their drug formularies mid-policy year, (2) requires health insurers to provide certain information to assist consumers in comparing health insurance plans, and (3) requires the Department of Insurance[1] to evaluate health insurers' compliance with the Affordable Care Act.

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents the country's leading innovative biopharmaceutical research and biotechnology companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. In 2013, biopharmaceutical companies invested more than $51.1 billion in the discovery and development of medicines.

Protecting Patients From Discriminatory Insurance Design

Before the passage of the Affordable Care Act (ACA), insurers could deny consumers health care coverage based on a pre-existing condition or could charge higher premiums based on a known health condition or past medical history. Although ACA prohibits health plans from discriminating against patients based on health status, the AIDS Institute and the National Health Law Program filed a complaint in 2014 with the federal Department of Health and Human Services Office for Civil Rights[2,3] alleging that four health insurance companies operating in Florida's Health Insurance Exchange were violating certain discrimination protections for persons living with HIV/AIDS based on plans' coverage and cost-sharing requirements for certain HIV/AIDS-related prescription drugs.[4] The complaint alleged that while these insurers covered many HIV/AIDS medicines, the plans' discriminatory practices placed all of the HIV/AIDS drugs covered by their formularies at the highest cost-sharing tier while this benefit design practice was not instituted for other diseases. In separate settlements, all four plans have changed their formularies for 2015 to lower consumers' cost-sharing responsibility for AIDS drugs.

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1 An earlier draft of this statement incorrectly stated that the Connecticut Health Insurance Exchange and Department of Insurance should jointly review plans for ACA compliance. However, only the Department of Insurance has such authority. We regret this error.
[2] OCR has the legal authority for enforcing certain protections against discrimination under the Affordable Care Act (ACA)
3 The states maintain similar enforcement authorities under the ACA, and, in fact, are permitted to enact even more stringent consumer protections.
[4] The four plans are Coventry Health Care, Inc., Cigna, Humana and Preferred Medical. See AIDS Institute and NHeLP Administrative Complaint dated May 29, 2014, http://www.healthlaw.org/issues/disability-rights/HHS-HIV-Complaint#.VBY3Qlaaq2w.

Inspired by the Florida case, the Department of Health Policy and Management at Harvard School of Public Health investigated formulary tiering for HIV medicine in 12 states using the federal Marketplace and published its findings in the January 2015 issue of the New England Journal of Medicine. Researchers found "evidence of adverse tiering in 12 of the 48 plans [reviewed]...adverse-tiering plans (ATPs) enrollees had an average annual cost per drug of more than triple that of enrollees in non-ATPs ($4,892 vs. $1,615)." In addition, an Avalere Health analysis of Exchange plans found that over half of reviewed formularies place all analyzed oncology and multiple sclerosis products on the highest formulary tier.

Given that discriminatory practice in formulary design has been documented in Exchange plans across the nation, PhRMA believes that SB 24 takes a good first step at making needed medicines more accessible to patients by prohibiting insurers from offering drugs in non-preferred or higher cost-sharing tiers unless the plan covers at least one drug per medicine class that would be considered a medically appropriate alternative for a given health condition at preferred pricing. This will ensure that providers and patients will have at least some choice of medicines within drug classes at a preferred price.

Prohibiting Negative Changes to Formularies During the Plan Year

When a patient enrolls in a plan, they are locked into that plan for one year and, therefore, the insurer should not 1) be permitted to change the drug formulary by moving a drug to a tier with increased cost sharing, 2) be able to remove a drug from the formulary, or 3) should not add utilization management to a drug during the plan year, unless a generic equivalent becomes available. Negative changes to drug coverage can interrupt a patient's drug treatment regimen and result in unexpected, added costs for both the patient and the health care system (e.g., added physician, hospital, and emergency room visits for adverse reactions resulting from such treatment disruption). A preliminary Avalere Health analysis of four medicine classes offered on formularies at six health plans shows that in five of these plans, at least one class saw a 15% reduction of covered products during the plan year. Such practices are unfair given that patients are likely to choose a plan that specifically covers certain drugs. Considering that patients cannot switch plans during the plan year, any ability for plans to employ practices that could disrupt a treatment regimen or lead to poorer health outcomes should be restricted.

Providing Certain information to Assist Consumers in Comparing Health Insurance Plans

Connecticut has made great strides in providing information to patients on AccessHealth CT, but there is additional information that could make selecting a plan easier for patients. For example, in Connecticut, information about drug formularies and cost-sharing is not displayed with the initial cost-sharing examples for premiums, physician visits, and emergency room visits. PhRMA is concerned that patients may not have necessary information available to them prior to purchasing a plan on or off of the Exchange. Consumers therefore may not be making an informed decision about which plan best meets their needs. Without selecting the right health plan, many consumers face being underinsured; may have higher out of pocket costs that might have otherwise have been reduced; or may jeopardize their health because financial hardships may keep them from accessing needed care. Enabling the

consumer to access information in a clear, transparent, simple, and accurate manner will allow for better understanding of coverage and cost sharing responsibilities prior to purchasing insurance.

This objective can be met by requiring that access to information about each plan's covered benefits be posted publicly on its website. Information should include but not be limited to: the providers and hospitals in the plan's network; the drugs on the formulary and the corresponding cost-sharing; the specific copayment or coinsurance for each covered item or service; and the process for a patient to receive an exception to a denied service or appeal for coverage of a non-covered, but medically necessary service.

Complying with the Non-Discrimination Language in ACA

In addition, PhRMA believes that plans providing essential health benefits should submit the information discussed above to aid consumers in decision-making to the Department of Insurance in a machine readable format. This will help the state and researchers evaluate plans so that plans do not knowingly or unknowingly create a benefit design that discriminates against patients with a certain health condition or conditions.

In summary, to ensure that consumers are protected against discriminatory insurance design and will not experience mid-year formulary changes, have the best coverage and cost-sharing information about health plans and that the state has this information in an easy to analyze format to oversee compliance, PhRMA strongly urges Connecticut legislators to support Senate Bill 24.